Washington State Department of Social & Health Services

KIDNEY DISEASE PROGRAM (KDP)
APPLICATION FOR ELIGIBILITY

Instructions: Please read each part carefully. Print your answers in the appropriate spaces using a ballpoint pen. All spaces in Part I, Part II, and Part III must be completed.

1. NAME OF THE KIDNEY CENTER

PART I . PERSONAL INFORMATION

2. NAME (FIRST, MIDDLE INITIAL, LAST)	3. DATE OF BIRTH	4. SOCIAL SECURITY NUMBER (SSN)

5. MAILING ADDRESS	CITY	STATE	ZIP CODE

6. HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	7. EMPLOYER	8. OCCUPATION

9. SEX
☐ Male
☐ Female

10. ETHNIC GROUP
☐ Caucasian (white) ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Other (specify)

10. List family members living in your household that you are financially responsible for, DO NOT INCLUDE YOURSELF.

NAME	DATE OF BIRTH	RELATIONSHIP	SSN

PART II. THIRD-PARTY COVERAGE (ANSWER ALL OF THE FOLLOWING QUESTIONS.)

1. Are you covered by Medicare? **Part A?** ☐ Yes ☐ No **Part B?** ☐ Yes ☐ No

   Do you have a Medicare Supplement **OR** other Health Insurance? ☐ Yes ☐ No

2. If yes, name of insurance: _____ Group number: _____ I.D. number: _____

   Have you applied for medical assistance from the Department of Social and Health Services (DSHS), Community Services Office (CSO) in the last six months? ☐ Yes ☐ No

3. If yes, mark the determination letter you received below and attach a copy.

   ☐ Medical Award Letter - You qualified to receive medical assistance.
   ☐ Denial Letter - You did not qualify for medical assistance.
   ☐ Applicant Liability - You did not qualify because of a spenddown liability.

   Enter the dollar amount of your spenddown liability: $ _____ for: ☐ three (3) months **OR** ☐ six (6) months

   ☐ Other: _____

PART III. INCOME AND RESOURCES

Annual Family Household (Use annual totals for all items) All spaces must be completed with a dollar amount. Do not mark "none;" instead, insert "0" if there is no dollar amount.

ANNUAL INCOME	YOURS	SPOUSE/ OTHER
1. Gross annual salaries/wages	$	$
2. Disability insurance (Social Security, private or government)	$	$
3. Social Security retirement	$	$
4. Retirement pension	$	$
5. Business property, rental income	$	$
6. Interest (savings, etc.)	$	$
7. Dividends, royalties	$	$
8. Child support received, alimony	$	$
9. Unemployment compensation	$	$
10. Public assistance	$	$
12. Other (specify)	$	$
Total annual family income	$	

RESOURCE	YOURS	SPOUSE/ OTHER
1. Savings, IRA's, etc.	$	$
2. Stocks, Bonds	$	$
3. Contracts	$	$
4. Other Real Estate. Attach Tax Assessment. DO NOT INCLUDE PRIMARY HOME.	$	$
5. Annuities	$	$
6. Insurance - cash value	$	$
7. Personal property (do not include primary car)		
2nd car - Make _____ Year _____	$	$
3rd car - Make _____ Year _____	$	$
Other vehicles (boats, motorcycles, farm equipment, RVs)		
Type _____	$	$
Type _____	$	$
8. Other resources		
Value of assets given away (in the last 2 years)	$	$
Court ordered awards to you	$	$
Non medical insurance benefits	$	$
Other (specify) _____	$	$
Total family resources	$	

EXPLANATION/REMARKS (PLEASE PRINT)

I assign this Kidney Center my rights to any third-party payments to pay for covered medical services while I receive medical assistance.

I declare under penalty of perjury that the information given by me in this declaration is true, correct, and complete to the best of my knowledge. I will promptly notify the Kidney Center of any substantial change in my income or resources. I realize that willful falsification of this information may make me ineligible to receive help with my medical bills. I agree to send copies of IRS forms or other verification, if requested.

SIGNATURE OF APPLICANT (OR LEGAL GUARDIAN)	DATE

KIDNEY CENTER USE ONLY

KDP CLIENT STATUS
Client is: ☐ New ☐ Reapplying
☐ Update to current eligibility information

Client is eligible for KDP assistance starting _____ through _____

IF REAPPLYING, ENTER CLIENT ID NUMBER

CLIENT HAS **KDP ANNUAL DEDUCTIBLE** ☐ Yes ☐ No

ENTER AMOUNT OF THE ANNUAL DEDUCTIBLE $

I hereby certify that the applicant is eligible according to information provided on the Application for Eligibility, DSHS 13-566, as set forth in WAC 388-540 and the Kidney Disease Program Contract Manual.

KIDNEY CENTER OFFICIAL	DATE